



DIXIE ORAL MAXILLOFACIAL & IMPLANT SURGERY

St. George Office:
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St. George, UT 84790 435-673-1554

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Cedar City, UT 84721 435-867-1474

BOARD CERTIFIED, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

PATIENT REGISTRATION

Date: _____ Best Phone to Reach You About Your Appt: _____

May we leave a message regarding your appointment? : Yes | No

Patient: _____ Marital Status: _____

Last Name First Name Middle Initial

E-mail Address: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Sex: M ___ F ___ Age: _____ Birth Date: _____ S.S. # _____

Employer: _____ Employer Phone: _____

Spouse Name: _____ Spouse's Employer: _____ Employer Phone: _____

Closest relative not living with you: _____ Phone: _____

Whom may we thank for referring you? _____

Who is your General Dentist? _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Heart Problems	___	___	Sinus Problems	___	___	Nervous Problems
___	___	Artificial Heart Valves	___	___	Stroke	___	___	Psychiatric Care
___	___	Artificial Joints	___	___	Blood disease	___	___	Chemical Dependency
___	___	Rheumatic Fever, Murmur	___	___	Bleeding Disorder	___	___	Back Problems
___	___	High Blood Pressure	___	___	Hepatitis, Jaundice	___	___	Arthritis
___	___	Shortness of Breath	___	___	or Liver Disease	___	___	Venereal Disease
___	___	Circulatory Problems	___	___	Kidney Disease	___	___	AIDS / Other Immuno-
___	___	Lung Disorder	___	___	Chronic Diarrhea	___	___	suppressive Disorder
___	___	Asthma	___	___	Ulcer	___	___	Allergies to Anesthetic
___	___	Thyroid Disease	___	___	Diabetes	___	___	Allergies to Medicines
___	___	Epilepsy	___	___	Special Diet	___	___	or Drugs
___	___	Headaches	___	___	Recent Weight Loss	___	___	General Allergies
___	___	Swollen Neck Glands	___	___	Cancer	___	___	Sleep Apnea (use
___	___	Radiation Treatment						CPAP)

Do you have any drug allergies or have you ever had any adverse reaction to any medication? _____ If so, please explain

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medications at this time? _____ If so, what? _____

Have you taken any oral or IV medications called Bisphosphonates? (i.e. Zometa, Aredia, Fosamax, Actonel, Boniva) ___ Yes ___ No

Are you under the care of a physician? ___ Yes ___ No For what condition? _____

Do you use tobacco? ___Yes ___ No If yes: do you ___ Smoke(cigarettes) or use Smokeless (Chewing tobacco) Frequency: ___
Female Patients: Do you suspect that you are pregnant? ___Yes ___ No Trimester ___ Are you nursing? ___Yes ___ No
Is there anything else we should know about your medical history including the use of herbs or health supplements?

PERSON RESPONSIBLE FOR PAYMENT

If you are a parent bringing a minor, the signer of the registration and financial agreement will be listed as the responsible party.
(If you are 18 years of age or older you are the person responsible and signing all forms.)

Name _____ Circle one (Self, Parent, Legal Guardian)

P.O. Box /

Street Address: _____

Home Phone: _____

Work Phone: _____

Employer: _____

Cellular / Daytime Phone: _____

Responsible Party's Driver's License Number: _____

S.S. #: _____

Date of Birth _____

INSURANCE INFORMATION

Medical / Dental Insurance is a contract between the insured and the insurance carrier. The patient is responsible to our office for the total fees charged for services rendered. We are happy to bill your insurance company as a service to you if you supply us with the necessary information.

Primary Medical / Dental (Circle One)

Secondary Medical / Dental (Circle One)

Insurance Company: _____

Insurance Company _____

Name of Policy Holder: _____

Name of Policy Holder: _____

Date of Birth of Policy Holder: _____

Date of Birth of Policy Holder: _____

Employer: _____

Employer: _____

Member ID.#: _____

Member ID.#: _____

Relationship to Patient _____

Relationship to Patient _____

Insur Co Address: _____

Insur Co. Address.: _____

Phone #: _____

Phone #: _____

The information on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors of omission that I may have made in completing the form.

I have read and / or been furnished with a copy of the "Notice of Privacy Practices" for Dixie Oral, Maxillofacial and Implant Surgery.

I agree to pay in full all fees that are incurred during my dental treatment or treatment of the above patient. I also understand that I am responsible for any balance not paid by my insurance company.

Patient's Signature

Date

Parent / Guardian's Signature

Date